Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005089	A. BUILDING: _____ B. WING _____	11/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S MEDICAL CENTER	3700 WASHINGTON AVE EVANSVILLE, IN 47750

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for a State complaint investigation. Complaint # IN00157381 Unsubstantiated; lack of sufficient evidence. Survey date: 11/13/14 Facility: #005089 Surveyor: Trisha Goodwin, RN BS Public Health Nurse Surveyor St. Mary's Medical Center is in compliance with 410 IAC 15-1.5-6, Nursing service, Hospital Licensure Rules. QA: claughlin 01/07/15	S 000		

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE